DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 7722 27

State of Maryland

1. PLACE OF DEATH:
(a) County: Anne Arundel
(b) City or town: Fort George G. Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Regional Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days; In this community: 1 month 15 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ohio (b) County: Unknown
(c) City or town: Galion (If outside city or town limits, write RURAL)
(d) Street No.: 390 Grove Ave (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME: ADAMS, Howard D 0-1705311
3. (b) If veteran, name war: –
3. (c) Social Security No.: –
4. Sex: Male
5. Color or race: W
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Barbara Sue Adams
6. (c) Age of husband or wife if alive: – years
7. Birth date of deceased: May (Month) 2 (Day) 1918 (Year)

8. AGE: Years: 27 | Months: 3 | Days: 21 | If less than one day: _____ hr. _____ min.

9. Birthplace: Unknown (City, town, or county) (State or foreign country)
10. Usual occupation: Officer
11. Industry or business: US Army
MOTHER FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: MD AGO Form 66-1
(b) Address: Office s Qualification Card USA
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/23/45 (Month) (Day) (Year)
(c) Place; burial or cremation: Galion, Ohio
18. (a) Signature of funeral director: Howard D Blight Jr.
(b) Address: 4914 Belair Rd Baltimore Md
19. (a) 23 Aug 45 (Date received local registrar) (b) J.A. Crawford Jr. (Registrar's signature) J.A. CRAWFORD, JR. 2nd Lt MAC

MEDICAL CERTIFICATION

20. Date of death: Month August day 22
year 1945 hour 3:20 PM minute _____
21. I hereby certify that I attended the deceased from 21 August, 1945 to 22 August, 1945 that I last saw him alive on 22 August, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia, bronchial both lower lobes and lt middle lobe	
Due to: Cause unknown	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

PHYSICIAN

Major findings:
Of operations: –
Of autopsy: Confirmed as above

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): –
(b) Date of occurrence: –
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? –
While at work? – (Specify type of place) (e) Means of injury: –

23. Signature: A.J. SCHAFFER Lt Col (M. D. or other) AMC
Address: Ft Meade Md Date signed 23 Aug 1945

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

07667 20

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Broadwater Beach, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Broadwater Beach, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Churchton, Md. P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN CARL ALLEN

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie Lee Allen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 22, 1904

8. AGE: Years	Months	Days	If less than one day
41	7		..... hrs. ..... min.

9. Birthplace: Benson, North Carolina
(Town, county, and state)

10. Usual occupation: Real Estate

11. Industry or business:

FATHER — 12. Name: Jesse Allen

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: J. M. Massey

MOTHER — 15. Birthplace: North Carolina

16. Informant: Mrs. Annie Lee Allen

Address: Broadwater Beach, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 24, 1945 (month) (day) (year)

Cemetery or crematory: BENSON, N. Carolina.

Location: BENSON, NORTH CAROLINA

18. Funeral director: Martin W. Hysong Co.

Address: 1300-N St. N.W. - Washington, D.C.

19. Aug 22 1945 (Date rec'd by Registrar) W. M. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 1945 to August 21 1945 and that I last saw him alive on August 21 1945

Immediate cause of death	DURATION
Internal Hemorrage; Causes Unknown, cured.	2 or 3 hours.
Due to: Acute Myocarditis	
Due to: Not Determined	
Other conditions: He Bled profusely from nose and mouth, two hours before he died. (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. B. Hest M.D.
M. D. or other

Address: Lothian, Md. Date signed: 8/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

07723

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 1/2 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5010 Ritchie Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY BALINT

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Balint
Deceased
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 18, 1887

8. AGE:

Years	Months	Days	If less than one day
58	3	21	..... hrs. ..... min.

9. Birthplace: Fekte Hegy, Basca Banet Co. Hungry
(Town, county, and state)
10. Usual occupation: Food inspector (Retired)
11. Industry or business: General Foods Hoboken, N.J. Franklin Baler Coconut Div'n.

FATHER
12. Name: Szandor Bordasz
13. Birthplace: Hungry

MOTHER
14. Maiden name: Lydia Sarandy
15. Birthplace: Hungry

16. Informant: Frank Balint
Address: 5010 Ritchie Hwy. Brooklyn Pk. Md.

17. Ship (Burial, cremation, or removal. Which?) Date thereof Aug. 9, 1945 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Fairview, N.J. Jersey City
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. Aug 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 19 45 at 2.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45 to Aug 9 19 45
and that I last saw h... alive on Aug 9 19 45

Immediate cause of death	DURATION
generalized carcinomatosis	
Due to: carcinoma uteri	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: P. W. Kaiser MD M. D. or other
Address: 302 Potapsco Av Date signed: Aug 9 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Fraiew Valent.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-B

CERTIFICATE OF DEATH

07724

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Elvaton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Elvaton (Millersville R.F.D.)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Jumper Hole Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Abraham Lincoln Barlow

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Meta Barlow

Nee Miller 6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.): February 14, 1870

8. AGE: Years	Months	Days	If less than one day
75	6	16	....hrs. ....min.

9. Birthplace: Minnisota (Town, county, and state)

10. Usual occupation: Crain Operator (Retired)

11. Industry or business: B & O Railroad

FATHER 12. Name: George Barlow

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Meta Barlow

Address: Elvaton, Millersville Md. R.F.D

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1945 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Sept 2 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1945, at 7.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23rd 1945 to Aug 31st 1945

and that I last saw him alive on Aug 30th 1945

Immediate cause of death	DURATION
Carcinoma of Tongue	about 8 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John F. Alexander M. D. or other

Address: Glen Burnie Date signed: 9/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

07725

State File No. _____
Registrar's No. 27

State of MARYLAND (Md)

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Fort George G. Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Regional Hospital Ft. Geo. G. Meade, Md (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Dead on arrival (Specify whether years, months or days)
In this community 6 Oct 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Germany (b) County Derfetr 23
(c) City or town Gensa, Mersedurg (If outside city or town limits, write RURAL)
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME BAUER, Hugo
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Else Ba uer
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July (Month) 1 (Day) 1904 (Year)

8. AGE: Years 41 | Months 1 | Days 9 | If less than one day _____ hr. _____ min.

9. Birthplace Germany (City, town, or county) (State or foreign country)
10. Usual occupation Soldier
11. Industry or business German Army

MOTHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Prisoner of War Records
(b) Address U. S. Army

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (Month) (Day) (Year)
(c) Place; burial or cremation Post Cemetery Fort George G. Meade, Md.

18. (a) Signature of funeral director Howard W. Blight Jr.
(b) Address 4914 Belair Road

19. (a) 10 August 45 (Date received local registrar) (b) W. J. Lawson Jr. (Registrar's signature)
W. J. LAWSON, JR. 1st Lt MAC

MEDICAL CERTIFICATION

20. Date of death: Month August day 10
year 1945 hour 7:20 AM minute _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____:
that I last saw h____ alive on _____, 19____:
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Emil Waldenburgh (M. D. or other)
Address Ft Geo. G. Meade, Md Date signed 10 Aug 45

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (152)

CERTIFICATE OF DEATH

07726

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, Institution, or street address where death occurred: Regional Hospital, Fort George G. Meade, Md

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Germany County: -

City or town: Koblenz q/Rhein (If outside city or town limits, write RURAL and give nearest town)

Street No.: Bannhoffstrasse 31 (If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: BAUNACH, George (NMI) POW

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maria Baunach

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): May 23, 1911

8. AGE:

Years	Months	Days	If less than one day
34	2	13	- hrs. - min.

9. Birthplace: Koblenz, Germany (Town, county, and state)

10. Usual occupation: Prisoner of War

11. Industry or business: -

FATHER
12. Name: -
13. Birthplace: -

MOTHER
14. Maiden name: -
15. Birthplace: -

16. Informant: Prisoner of War Records

Address: U. S. Army

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 1945 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort George G. Meade, Md.

18. Funeral director: Howard M. Blight Jr. Howard Blight

Address: 4914 Belair Rd., Balto., Md.

19. 4 August 1945 (Date rec'd by registrar)

J. A. CRAWFORD Jr. Asst Registrar

2d Lt. MAC.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 August 1945 at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1630 3 August 1945, to 3:50 a.m 4 Aug. 45 and that I last saw him alive on 4 August 1945

Immediate cause of death	DURATION
Ludwig's Angina	
Respiratory obstruction	11 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Tracheotomy

Date of op. 3 Aug 1945

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: Albert A Kinnen 1st Lt MC (M. D. or other)

ALBERT A. KINNEN, 1st Lt. M.C.

Address: Reg Hosp Ft Meade Md Date signed: 4 Aug 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07727

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 27 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 4 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -------- Balto.

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 118 Blainway, Sparrows Point (If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BLACK - JAMES L.

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Gladys Black

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1908

8. AGE: Years	Months	Days	If less than one day
37	unknown		----- hrs. ----- min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: -------

FATHER — 12. Name: Martin Black

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Nancy Clark

MOTHER — 15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23-45 (month) (day) (year)

Cemetery or ~~crematory~~: Hospital

Location: Crownsville

18. Funeral director: Asst. Hospital

Address: Crownsville Md

19. (Date rec'd by registrar) July 25 1945 — E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1945, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1945, to August 17 1945 and that I last saw him alive on August 17 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 3/22/45
Due to: ----------	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op. ----------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of ----------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work? ----------

23. SIGNATURE: Albert J. Dinsmore M. D. or other

Address: Crownsville, Maryland Date signed 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

07668

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel,
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years.
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital.
How long in hospital or institution? 17 July 1945 29 August 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel.
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 213 King George St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish-American. WorldWar 1

3.(a) FULL NAME: Colonel James Thomas BOOTES, USMC (Ret.Inac).

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White-US	Married

6.(b) Name of husband or wife: Anna C. Bootes.
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): 8 December 1862.

8. AGE: Years	Months	Days	If less than one day
82	8	21	1 hrs. 10 min.

9. Birthplace: Wilmington, New Castle, Delaware.
(Town, county, and state)
10. Usual occupation: Retired.
11. Industry or business: U.S. Marine Corps.
FATHER 12. Name: L. C. Bootes.
13. Birthplace: Washington, D.C.
MOTHER 14. Maiden name: Mary L. Bird,
15. Birthplace: Delaware.
16. Informant: Mrs. AnneBootes Sutherland, Daughter.
Address: 213 King George St., Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 31 1945 (month) (day) (year)
Cemetery or crematory: U.S. NATIONAL CEMETARY
Location: U.S. Naval Academy, Annapolis, Md.
18. Funeral director: John M. Taylor,
Address: 147 Duke of Glouscester St., Annapolis, Md.
19. Aug. 30 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 August 1945 19 at 0110 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1945 to Aug 29 1945 and that I last saw h... alive on 8-29-45 19...

	DURATION
Immediate cause of death: Cerebral Embolism	3 hrs.
Due to: Coronary Occlusion	several months
Due to: arteriosclerosis	yrs.
Other conditions: generalized	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: Never
Autopsy results: Subdural Hemorrhage - organized
PHYSICIAN: Please underline the cause to which death should be charged. Officially

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Richard L. Bramble M. D. or other
Address: U.S.N. Hospital, Annapolis, Md. Date signed: 8-29-45

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

07669

CERTIFICATE OF DEATH

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs, 4 mos, 7 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 yrs, 4 mos, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2359 McCulloh St.
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME
CARRINGTON - ALICE

3.(b) Social Security Number
----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	Black	Single

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1916

8. AGE: Years: 29 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business: ------

FATHER
12. Name: N. B. Carrington
13. Birthplace: unknown

MOTHER
14. Maiden name: Jennie Tinsley
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 31, 1945 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location: Baltimore Co. Md.

18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave.

19. 8/31 19 45 (Date rec'd by registrar) B. B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 19 45 at 2:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 19 39 to August 28 19 45
and that I last saw her alive on August 28 19 45

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Known to us since
Due to: --------	7/9/45
Due to: ----------	
Other conditions: Schizophrenia - Paranoid Type (Include pregnancy within 3 months of death)	Known to us since 6/23/39

Major findings of operations: -------
Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: -------- Injured at work? -----

23. SIGNATURE: Hattie V. Smith Cook M. D. or other
Address: Crownsville, Maryland Date signed: 8/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

07678 28

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 14 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 3 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -----

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war unknown

3.(a) FULL NAME COLE - JOHN R.

3.(b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married & separated

6.(b) Name of husband or wife unknown

B.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) December 29, 1882

8. AGE: Years	Months	Days	If less than one day
62	7	20	---hrs. ---min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business unknown

FATHER 12. Name John R. Cole

13. Birthplace Maryland

MOTHER 14. Maiden name Emma ?

15. Birthplace Maryland

18. Informant Hospital Records

Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-45 (month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Baltimore

18. Funeral director Raymer Sanders

Address 1412 E. Preston St.

19. 8/18 1945 H. C. Hodnett M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1945, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1945, to August 17 1945

and that I last saw him alive on August 17 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 5/4/45
Due to -------	
Due to -------	
Other conditions Senile Psychosis	Known to us since
confused and delirious state	5/4/45

(Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE H. C. Hodnett M. D. or other

Address Crownsville, Maryland Date signed 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-a)

CERTIFICATE OF DEATH

07671 P

Reg. Diat. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Marley Park, P.O. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years.

Hospital, Institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel.

City or town Marley Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. The Causeway Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Marion Calhoun.

3.(b) Social Security Number 214-01-5879

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of husband or wife Margaret Michael

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1875 (1875)

8. AGE: Years 69 Months 11 Days If less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Freeman.

11. Industry or business

FATHER 12. Name Albert Calhoun

13. Birthplace Md.

MOTHER 14. Maiden name Jessie Steven

15. Birthplace Md

16. Informant George H. Calhoun (Son)

Address Marley Park, P.O. Glen Burnie.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/14-45 (month) (day) (year)

Cemetery or crematory Glen Haven Mem

Location Crownsville Rd & Co

18. Funeral director Edward Fontaine

Address 2359 Wash Blvd

19. 8/3 1945 Dupont (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to Aug. 1st 1945 and that I last saw him alive on 7/31/45 1945

	DURATION
Immediate cause of death Mitral Insufficiency	+ 4 months
Due to Chronic Interstitial nephritis.	+ 4 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations NO Date of op.

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave H. Bauer M.D. M. D. or other

Address Glen Burnie, Md Date signed 8/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07672

★ Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs., 3 mos., 17 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 12 yrs., 3 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Welbourne
(If outside city or town limits, write RURAL and give nearest town)
unknown
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: COLLINS - MAGGIE

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years	Months	Days	If less than one day
46	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Hope Cemetery
Location: Welbourne, Maryland

18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City, Maryland

19. Aug. 24 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1945 at 4:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1933 to August 20 1945 and that I last saw h er alive on August 20 1945

Immediate cause of death	DURATION
Tuberculosis of the Lungs	Known to us since 3/6/45
Due to: ----	
Due to: ----	
Other conditions: Dementia Praecox	Since 1933

(Include pregnancy within 3 months of death) ----

Major findings of operations: ----
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

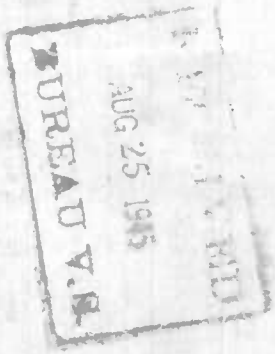
22. VIOLENCE: If death was due to external causes, fill in the following: ----
Accident, suicide, or homicide: Date of ----
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold H. Smith M. D. or other 10/45
Address: Crownsville, Maryland Date signed

3875

Collins - Maggie
Worcester County
Admitted - May 3, 1933

Died - August 20, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07673

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs., 6 mos., 16 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 yrs., 6 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 N. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3.(a) FULL NAME: CRUTCHFIELD - MARGARET

3.(b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

B.(b) Name of husband or wife: --------
B.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE:	Years	Months	Days	If less than one day
	33	unknown		---- hrs. ----- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ------

FATHER
12. Name: Richard Crutchfield
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Johnson
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug. 8, 1945 (month) (day) (year)
Cemetery or crematory: Hati
Location: Rockville, Maryland

18. Funeral director: Robert P. Snowden
Address: Rockville, Maryland

19. Aug. 4 (Date rec'd by registrar) 19 45 Mr. E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 19 45 at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 19 32, to August 4 19 45 and that I last saw h... alive on August 4 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Apprx. 2 mos.
Due to: ----------
Due to: ----------
Other conditions: Dementia Praecox — Known to us since 1/18/32
(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: ------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ----------
Accident, suicide, or homicide: Date of ----------
Where did injury occur? (City or town) (County) (State) ----------
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? --------

23. SIGNATURE: Hart J. Stinebraker M. D. or other
Address: Crownsville, Maryland Date signed 8/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

07674

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred:

314 adams St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 adams St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Earnest Daniels

3.(b) Social Security Number 215-09-4602

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Sarah T. Daniels

B.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) march 11 - 1889

8. AGE:

Years	Months	Days	If less than one day
56	5	4	hrs. min.

9. Birthplace maryland (Town, county, and state)

10. Usual occupation operator

11. Industry or business

FATHER 12. Name John W. Daniels

13. Birthplace maryland

MOTHER 14. Maiden name Rose Ivy Gardner

15. Birthplace maryland

18. Informant Sarah T. Daniels

Address 314 adams St Eastport

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug 18 45 (month) (day) (year)

Cemetery or crematory St Mary's

Location annapolis. md

18. Funeral director B. L. Hopkins

Address annapolis. md

19. Aug. 17 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 45, at 12 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 45, to Aug 15 19 45

and that I last saw h alive on Aug 14 19 45

Immediate cause of death Myocardial Chronic Coronary Insufficiency

DURATION: 7 years 6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other

Address annapolis md Date signed 8-15- 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

17675

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Pearline Dorsey

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): August 28 1943
8. AGE: Years | Months | Days | If less than one day: 22 hrs. ..... min.
9. Birthplace: Gambrills, Md Rural (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Samuel Dorsey
13. Birthplace: A.A. Co Md

MOTHER
14. Maiden name: Rosa Howard
15. Birthplace: Gambrills Md

16. Informant: Samuel Dorsey
Address: Gambrills Md

17. (Burial, cremation, or removal. Which?) Date thereof: 8-30-43 (month) (day) (year)
Cemetery or crematory: Mt Tabor
Location: A.A. County Md

18. Funeral director: Russell Dorsey
Address: Gambrills Md

19. 8/30 43 E T Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1943 at 1AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 1943 to Aug 29 1943 and that I last saw alive on Aug 29 1943

Immediate cause of death	DURATION
Premature birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: O'Hara Neuman M. D. or other
Address: Millersville, Md Date signed: 8-30-43

07676

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH. A. A.

County ..... A. A.

City or town Annapolis.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred: 11 Pleasant Court.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Pleasant Court.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Dolores Evelyn Dozier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colored	single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5 1945

8. AGE: Years ..... Months ..... Days 27 ..... If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis. (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER — 12. Name Rexxil M. Dozier

13. Birthplace La.

MOTHER — 14. Maiden name Mary Evelyn Johnson

15. Birthplace Annapolis.

16. Informant Mary E. Johnson

Address 11 Pleasant Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 1945 (month) (day) (year)

Cemetery or crematory Brewer Hill.

Location Annapolis

18. Funeral director J. B. Johnson

Address Annapolis

19. August 3 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 19 45 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/31/45 19 to 8/2 19 45

and that I last saw h[illegible] alive on 8/1/45 19

Immediate cause of death	DURATION
Pneumonia	
Due to Faulty Diet	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M. J. K Lenahan Md

M. D. or other

Address 31 Smithsonian Ave Date signed 8/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 107677
Registrar's No. 27

State of MARYLAND

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Fort George G. Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Regional Hospital Ft Geo G Meade, Md. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 minutes (Specify whether years, months or days)
In this community –

2. USUAL RESIDENCE OF DECEASED:
(a) State Austria (b) County
(c) City or town Innsbruek 12 B (If outside city or town limits, write RURAL)
(d) Street No. 283 Arzler Str. (If rural, give location)
(e) If foreign born, how long in U. S. A.? – years.

3. (a) FULL NAME Ludwig ECKER
3. (b) If veteran, name war –
3. (c) Social Security No. –

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret Ecker
6. (c) Age of husband or wife if alive – years
7. Birth date of deceased January (Month) 14 (Day) 1902 (Year)

8. AGE: Years 43 | Months 7 | Days 21 | If less than one day – hr. – min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Unknown
11. Industry or business Unknown
MOTHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
FATHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Prisoner of War Records
(b) Address U. S. Army
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/45 (Month) (Day) (Year)
(c) Place; burial or cremation Post Cemetery Fort George G. Meade, Maryland
18. (a) Signature of funeral director Howard N. Blighton Jr.
(b) Address 4914 Belair Rd., Baltimore, Md.
19. (a) 7 August 1945 (Date received local registrar) W. J. Lawson Jr. (Registrar's signature) W.J.LAWSON, Jr., 1st Lt, MAC

MEDICAL CERTIFICATION

20. Date of death: Month August day 6
year 1945 hour 3:45 PM minute
21. I hereby certify that I attended the deceased from ~~Dec~~ on ~~19~~, ~~19~~ August 6, 1945 that I last saw him alive on August 6, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diphtheria	6 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations –
Of autopsy As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature Robt Kaplan 1st Lt MAC (M. D. or other) M.O.
Address Ft. Geo. G. Meade, Md. Date signed 8/7/45

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-e)

CERTIFICATE OF DEATH

07678

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: 204 Gloucester St.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mabel I. Fauble

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: L. Trail Fauble
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 23d 1840

8. AGE: Years	Months	Days	If less than one day
54	11	8	hrs. min.

9. Birthplace: Annapolis Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: James E. Lowman
13. Birthplace: Annapolis Md

MOTHER
14. Maiden name: Mary P. Haslup
15. Birthplace: Md.

16. Informant: L. Trail Fauble
Address: 204 Gloucester St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3d 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: Harry M. Layton Son
Address: Annapolis Md.

19. Sept 3 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31st 1945, at 1.9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1945, to Aug 31st 1945
and that I last saw h alive on Aug 31st 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Few hrs
Due to	
Due to	
Other conditions: Rheumatic Endocarditis	15 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Bond M. D. or other
Address: Annapolis Md Date signed: 8-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07679 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25

Hospital, institution, or street address where death occurred:

Broadwater — Woodlawn Heights

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Woodlawn Hgts Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. Glendale Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Dora Goldie Freburger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles Pumroy Freburger

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 1 - 1883

8. AGE: Years 62 | Months 6 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER

12. Name ? Reckord

13. Birthplace Unknown

MOTHER

14. Maiden name Margaret Reckord

15. Birthplace Unknown

16. Informant Mr. Charles P. Freburger Sr.

Address Glendale Ave. Woodlawn Hgts. Linthicum, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/27/45 (mooth) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Maryland

18. Funeral director WILLIAM J. TICKNER & SONS

Address Baltimore Maryland

19. Aug 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 21 1945, to Aug. 23 1945

and that I last saw h.. alive on Aug. 23 1945

Immediate cause of death Cardiac Vascular Disease — DURATION 4 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas L Bare M.D. M. D. or other

Address Linthicum Date signed 8-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

★ 0768022 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: District Training School Dist.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8years 10 mos. 14 days
Hospital, Institution, or street address where death occurred:
District Training School
How long in hospital or institution? 8 years 10 mos,14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Father 621 Kennedy St. N.W. D.C. Mother 6815 Calvert Ct. Riverdale, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Joan Ganey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 13,1930

8. AGE:	Years	Months	Days	If less than one day
	14	10	26	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: none
11. Indusfry or business: none

FATHER
12. Name: Lee Ganey
13. Birthplace: Missippi

MOTHER
14. Maiden name: Inez Benta
15. Birthplace: New Mexico

16. Informant: Records of District Training Sch.
Address: Laurel, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-7-1945 (month) (day) (year)
Cemetery or crematory: District Tr. School
Locafion: Laurel, Maryland

18. Funerat directfor: DeWitt H. Donaldson
Address: Laurel, Md.

19. Aug 8 1945 (Date rec'd by registrar) Clara Caslick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7th, 1945, at 5:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 1936, to August 7 1945
and that I last saw her alive on August 6, 1945

Immediate cause of death	DURATION
Convulsive Siezure	1 hr.
Epilepsy, Idiopathic	8 yrs.
Due to: Mental Deficiency, Idiocy	life
Due to: Idiopathic	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Antopsy results: none performed
PHYSICIAN: Please underline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James Linnard M.D
M. D. or other
Address: District Tr. School Date signed 8/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72)

CERTIFICATE OF DEATH

07681

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Ferry Farm - Ann

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Agnes Maria Geraci

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

8.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 13, 1901

8. AGE:

Years	Months	Days	If less than one day
44	5	2	____ hrs. ____ min.

9. Birthplace: Annapolis - A.A. - Md. (Town, county, and state)

10. Usual occupation: Civil Service - Naval A.

11. Industry or business

FATHER 12. Name: Frank B. Geraci

13. Birthplace: Annapolis, Md.

MOTHER 14. Maiden name: Agnes G. Smith

15. Birthplace: Annapolis, Md.

16. Informant: F. R. Geraci

Address: Ferry Farm, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18, 45 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor

Address: Annapolis, Md.

19. Aug. 17, 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15, 19 45, at 5-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 19 45, to Aug 15, 19 45, and that I last saw h.. alive on Aug 15, 19 45.

	DURATION
Immediate cause of death: Acute Congestive Heart Failure	Sudden
Due to: Oedema of the Lungs	"
Due to: Melancholia	2 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John M. Caffey M.D. (M. D. or other)

Address: Annapolis, Md. Date signed: 8/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

07682

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: (If outside city or town limits, write RURAL and give nearest town) Glen Burnie
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For stillborn infants give residence of mother)
State: Virginia County: Hanover
City or town: (If outside city or town limits, write RURAL and give nearest town) Bordeaux Mines
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mamie Grob

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Not Known 1876

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Maine Work
11. Industry or business:
FATHER — 12. Name: Wm Grob
FATHER — 13. Birthplace: Switzerland
MOTHER — 14. Maiden name: Unknown
MOTHER — 15. Birthplace: Germany
16. Informant: Mrs Becky
Address: Severna Park Md
17. Disposal (Burial, cremation, or removal. Which?) Date thereof 8/3/45 (month) (day) (year)
Cemetery or crematory: Richmond
Location: Va
18. Funeral director: J. J. Fahey & Sons
Address: 1318 Light St.
19. 8/3 1945 (Date rec'd by registrar) A. M. Helig Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1945, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1945, to Aug 2 1945, and that I last saw [illegible] alive on Aug 2 - 1945.

	DURATION
Immediate cause of death: Acute Coronary Thrombosis	4 days
Due to:	
Due to:	
Other conditions: Carcinoma - Colon	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Date signed Aug 3 - 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:
County ....
City or town .... (If outside city or town limits, write RURAL and give nearest town)
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED (For newborn infants give residence of mother)
State .... County ....
City or town .... (If outside city or town limits write RURAL and give nearest town)
Street No. .... (If rural, give LOCATION)

3. (a) FULL NAME
3. (b) Social Security Number

4. Sex
5. Color or race
6. (a) Single, married, widowed, or divorced
6. (b) Name of husband or wife
6. (c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days | If less than one day .... hrs. .... min.
9. Birthplace .... (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER: 12. Name
13. Birthplace
MOTHER: 14. Maiden name
15. Birthplace
16. Informant
Address
17. .... (Burial, cremation, or removal. Which?) Date thereof .... (month) (day) (year)
Cemetery or crematory ....
Location
18. Funeral director
Address
19. .... 19...... (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH .... 19......
21. I HEREBY CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...... to .... 19......; and that I last saw h...... alive on .... 19......
Immediate cause of death .... DURATION
Due to ....
Due to ....
Other conditions ....
(Include pregnancy within 3 months of death)
Major findings of operations ....
Autopsy results ....
PHYSICIANS: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (which?)
Means of injury .... Injured at work?

23. SIGNATURE .... M. D. or other
Registrar's address ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83rd)

CERTIFICATE OF DEATH

07683

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: A. A. Co't
City or town: Annapolis Jct.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis Jct.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Zoe Kirby Hammond

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife: ✓
If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 12. 1867

8. AGE: Years	Months	Days	If less than one day
77	6	23	hrs. min.

9. Birthplace: A. A. Co., Md. (Town, county, and state)
10. Usual occupation: Retired.
11. Industry or business:
FATHER — 12. Name: Philip J. Hammond
13. Birthplace: Md.
MOTHER — 14. Maiden name: Howard A. Kirby
15. Birthplace: Md.
16. Informant: Mrs. H. Fred. Owens
Address: Annapolis Jct., Md.
17. (Burial, cremation, or removal. Which?) Buried Date thereof 8/7/45. (month) (day) (year)
Cemetery or crematory: Savage
Location: Savage
18. Funeral director: Hewitt Donaldson
Address: Laurel, Md.
19. 8/5/45. 19 (Date rec'd by registrar) Frank Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4th 1945, at 10 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1st 1944 to Aug. 4th 1945
and that I last saw her alive on Aug. 4th 1945.

Immediate cause of death	DURATION
Cerebral Haemorrhage	3 days.
Due to: Hypertension	5 yrs.
Due to: Arterio-sclerosis	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley M.D.
M. D. or other
Address: Savage, Md. Date signed: 8/5/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07684 B

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Harman.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All her life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2m.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Anne Arundel.

City or town: Harman. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Carolina Gertrude Harman.

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Edwin R. Harman.

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb 19, 1863.

8. AGE: Years	Months	Days	If less than one day
82	6	10	— hrs. — min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: at home.

FATHER
12. Name: John Tuttle.
13. Birthplace: Delaware.

MOTHER
14. Maiden name: Olivia Stewart.
15. Birthplace: Maryland

16. Informant: Roger Harman.
Address: Harman. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/31/45 (month) (day) (year)

Cemetery or crematory: Friendship Cem.

Location: Anne A. Co., Md.

18. Funeral director: WM. J. TICKNER & SONS.

Address: Balto., Md.

19. 8/31 19 45 (Date rec'd by registrar) D. H. Heldrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 19 45, at 6 27 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45, to Aug 29 19 45, and that I last saw h.er alive on Aug 28 19 45.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 mos.
Due to: Senile Arteriosclerosis	5 years
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James S. Billingsley M. D.
M. D. or other

Address: Glen Burnie Md Date signed: Aug 30 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Addition of alias: Letter from Dr. Winterode adding this identification to Crownsville records and authorizing this Department to do likewise
Filmed 8-21-45 -.G 97;LL.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0768 28 P
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or Town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 1 mo., 2 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yrs., 1 mo., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: ---
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 738 W. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: HARRIS - JAMES (alias HARRY A. HOLLAND)

3. (b) Social Security Number: unknown ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1900

8. AGE: Years	Months	Days	If less than one day
44	8	21	--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Odd Jobs
11. Industry or business: ---

FATHER
12. Name: Ambrose Holland
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. 9 yr. (Burial, cremation, or removal. Which?) Date thereof Aug. 18 '45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore Md.
18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St.
19. 8/18 19 45 Alo Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 19 45, at 6:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 43, to August 15 19 45
and that I last saw him alive on August 15 19 45

Immediate cause of death	DURATION
General Paresis	Known to us since 7/13/43
Due to: ---	
Due to:	
Other conditions: ---	

(Include pregnancy within 3 months of death)
Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Hal V. Hazlett M. D. or other
Address: Crownsville, Maryland Date signed 8/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 07686 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A. Co., Md
City or town: FREETOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.,
City or town: Freetown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Hawkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Henrietta
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 70 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: A. A. Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Ike Hawkins
13. Birthplace: A. A. Co., Md

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Henrietta Hawkins
Address: Freetown A. A. Co, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 – 5 – 45 (month) (day) (year)
Cemetery or crematory: Marley Neck
Location: Marley Neck Road A. A. Co. Md

18. Funeral director: Bedia L. Brown & Son
Address: 08 W Montgomery St

19. Aug 4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/20/45 1945 to 8/2/45 1945
and that I last saw h alive on 8/1/45 1945

Immediate cause of death	DURATION
Coronary Artery Disease	6 Months
Due to:	
Due to:	
Other conditions: Peptic Ulcers	5 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Glen Burnie Md Date signed: 8/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 07687 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs, 1 mo, 6 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 26 yrs., 1 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: HAWKINS - WILLIAM

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years	Months	Days	If less than one day
52	unknown		--- hrs. ---- min.

9. Birthplace: Cheltenham, Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: -------

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-5-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.

18. Funeral director: Supt.
Address:

19. Sept-5-1945 (Date rec'd by registrar) E. Joyce Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1945 at 1:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1919 to August 22 1945 and that I last saw him alive on August 22 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Few hrs
Due to:	
Due to:	
Other conditions: Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	Known to us since 7/16/19

Major findings of operations: ------ Date of op. ------
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --------- Date of -----
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---------
Means of injury ------- Injured at work ------

23. SIGNATURE: Albert L. Tinsley M. D. or other
Address: Crownsville, Maryland Date signed: 8/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 07688

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 26 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: HOLMES - JESSE F.

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1908 ?

8. AGE: Years	Months	Days	If less than one day
37 ?	unknown		---hrs. ---min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Kent Brooks
13. Birthplace: Unknown

MOTHER
14. Maiden name: Hannah Smith
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/12/45 (month) (day) (year)

Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt Hospital
Address:

19. Aug 29 1945 (Date rec'd by registrar) E Hoye Lear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1945 at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1945 to August 10 1945 and that I last saw him alive on August 10 1945

Immediate cause of death: General Paresis — DURATION: Known to us since 6/5/45

Due to: ----------

Due to: ----------

Other conditions: ----------

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: -------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of: -------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Herbert Brookes M. D. or other

Address: Crownsville, Maryland Date signed: 8/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07689 28

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs., 1 mo., 21 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 11 yrs, 1 mo; 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Hagerstown
(If ontside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rnrel, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HOWARD - CLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1920 ?

8. AGE:

Years	Months	Days	If less than one day
25 ?	unknown		hrs. min.

9. Birthplace: Unknown
(Town, conuty, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23 45 (month) (day) (year)

Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt. Hospital
Address: Crownsville Md

19. Aug 23 1945 (Date rec'd by registrar) E J Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1945 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1934 to August 16 1945

and that I last saw him alive on August 16 1945

Immediate cause of death: Chronic Myocarditis — DURATION: Apprx. 2 mos.

Due to:

Due to:

Other conditions: Idiot with Epilepsy — Known to us since 7/25/34

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please nuderline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (Conuty) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry L. Pinkerton M. D. or other

Address: Crownsville, Maryland Date signed: 8/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07690

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Mt Zion

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gertie E Ireland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
X	W	widow

6.(b) Name of husband or wife James W Ireland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 22 - 1875

8. AGE: Years	Months	Days	If less than one day
69	9	1	..... hrs. ..... min.

9. Birthplace Calvert Co

(Town, county, and state)

10. Usual occupation Home work

11. Industry or business

FATHER 12. Name Samuel Brady

13. Birthplace maryland

MOTHER 14. Maiden name martha Lahney

15. Birthplace maryland

16. Informant Annie Seelers

Address Lothian Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 25 /45 (month) (day) (year)

Cemetery or crematory Mt Zion M E

Location Mt Zion Md

18. Funeral director B L Hopkins

Address Annapolis Md

19. Aug 24 45 (Date rec'd by registrar) H. M. Clayton by mw Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1945 at 4:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 1945, to Aug 23 1945 and that I last saw h.er alive on August 23 1945

Immediate cause of death	DURATION
Carcinoma of breast	
Due to Metastasis to bones	
Due to Pain of body	
Due to	
Other conditions Myocarditis Chronic	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F B West M D M. D. or other

Address Lothian Md Date signed 8/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07691

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Mulberry Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Mulberry Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma C. Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Isaac E. Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1870

8. AGE: Years	Months	Days	If less than one day
75	II	3	..... hrs. ..... min.

9. Birthplace: Mulberry Hill, A.A.Co. MD.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: James H. Little

13. Birthplace: A.A.Co.

MOTHER 14. Maiden name: Henretta Boone

15. Birthplace: A.A. Co.

16. Informant: Ceaser Johnson

Address: Mulberry Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 24, 1945 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: Skidmore, Md.

18. Funeral director: J.B.Johnson

Address: Annapolis, Md.

19. Aug. 24 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21, 1945, at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3, 1945, to Aug 21, 1945

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	2 Mo.
Due to:	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: H. E. Johnson M.D.

Address: 35 Northern Shore M. D. or other

Date signed: 8/23/60

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07692

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 4 months 18 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 years 4 months 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1315 West Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: GRACE JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Virgie Johnson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
39	?	?		

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ----

FATHER
12. Name: George Williams
13. Birthplace: Virginia

MOTHER
14. Maiden name: Fannie Thomas
15. Birthplace: Virginia

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Brooklyn A. A. Co.

18. Funeral director: Mrs. Ada Bailey

Address: 1421 E. Jefferson St

19. 8/31 19 45 A. W. Hedrick (Date rec'd by registrar) Registrar

D-07

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 19 45, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 12 19 43, to August 30 19 45

and that I last saw her alive on August 30 19 45

	DURATION
Immediate cause of death: General Parasis	April 12 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

--------, Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury: Injured at work?

23. SIGNATURE: Herbert J. Pinkerton M. D. or other

Address: Crownsville, Maryland Date signed: 8/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07693

Reg. Dist. No. 18

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester County
City or town: Church Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No. --------
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: JOHNSON - JOHN H.

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
70?			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: farmer
11. Industry or business: --------

FATHER
12. Name: John H. Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Robertson
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 20, 1945 (month) (day) (year)
Cemetery or crematory: Church Creek, Maryland
Location .....

18. Funeral director: J. J. Framptom and Son
Address: Federalburg, Maryland

19. Aug. 18 1945 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1945 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1945 to August 17 1945 and that I last saw him alive on August 17 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	Known to us since 7/25/45
Due to:	
Due to:	
Other conditions: Senile Psyshosis Confused and delirious type (Include pregnancy within 3 months of death)	Known to us since 7/25/45

Major findings of operations: --------
Date of op. --------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide: ------ Date of ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: August 18, '45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07694

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs., 4 mos., 28 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 20 yrs., 4 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3.(a) FULL NAME: JONES - ANNIE

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: --------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years	Months	Days	If less than one day
60	unknown		---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: --------

FATHER
12. Name: George Jones
13. Birthplace: unknown

MOTHER
14. Maiden name: Harriett Chase
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Dept Hospitals
Address: Crownsville

19. 9/1 1945 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 19 45 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 30 19 25 to August 28 19 45 and that I last saw her alive on August 28 19 45

Immediate cause of death	DURATION
Tuberculosis of the Lungs	Known to us since 7/15/45
Due to: --------	
Due to: --------	
Other conditions: Dementia Praecox - Paranoid Type (Include pregnancy within 3 months of death)	Since 1925

Major findings of operations: ----------
Date of op.: -----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Thos. J. Bimstead M. D. or other
Address: Crownsville, Maryland Date signed: 8/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9402)

07695

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Greenhaven.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(If nonnewborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Greenhaven

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 13 West Shore Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Magdelane Krebs

3. (b) Social Security Number

4. Sex: female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Frederick L. Krebs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 18, 1861

8. AGE: Years: 83 Months: 8 Days: 1 If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county and state)

10. Usual occupation: House wife

11. Industry or business: Home

FATHER 12. Name: unknown.

FATHER 13. Birthplace

MOTHER 14. Maiden name: unknown.

MOTHER 15. Birthplace

16. Informant: Mrs. Margaret Patzolike

Address: 3503 Silba Ave., Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 22 / 45 (month) (day) (year)

Cemetery or crematory: Dek Lawn Cemetery

Location: City

18. Funeral director: Ellicott Funeral Home

Address: 2098 Orleans St

19. 8/20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~xxxxxxxxxx~~ Postmortem Examination ~~xxxxxxxxxx~~ Aug 19 19 45

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary sclerosis	unknown
Due to: General Arterio-Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis Md Date signed: 8-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

07696 C

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A.

City or town: Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

2. Sweetser Rd.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Wade Hampton Linthicum

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Mary Delma Linthicum

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Feb. 14 - 1876

8. AGE:

Years	Months	Days	If less than one day
69	6	12	hrs. min.

9. Birthplace: Linthicum Md

(Town, county, and state)

10. Usual occupation: Retired —

11. Industry or business

FATHER

12. Name: Sweetser Linthicum

13. Birthplace: Linthicum Md.

MOTHER

14. Maiden name: Laura E. Quick

15. Birthplace: A. A. Co.

18. Informant: Sweetser Linthicum

Address: Linthicum, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/28/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 8/27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 26 1945, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1941, to Aug. 26 1945

and that I last saw him alive on Aug. 26 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	2 yrs.
Due to: Arterio-Sclerosis	4 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Ball Jr. M.D. M. D. or other

Address: Linthicum Date signed 8-26-1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH ★

07698

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
114 Duke of Gloucester Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 114 Gloucester Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Nicholson Magruder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years: 70 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Annapolis, A.A., Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: John R. Magruder
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Emily Nicholson
15. Birthplace: Annapolis, Md.

16. Informant: Peter H. Magruder
Address: 114 Gloucester St.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: August 6 1945
(month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Annapolis, Md.

18. Funeral director: Leon M. Taylor
Address: 147-149 Glucester Street

19. Aug 5 45
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to Aug 3 1945 and that I last saw h alive on Aug 3 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	18 hrs
Due to:	
Due to:	
Other conditions: Radical Operation Left Breast Cancer of the breast.	about 2 mos

(Include pregnancy within 3 months of death) Cwg.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Funeral Home Date signed: 8/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07697

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Last Few hours

Hospital, institution, or street address where death occurred: Police Station Annapolis Md

How long in hospital or institution? Few hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Jersey County:

City or town: Pine Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 E Third St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Bernard Marshall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Delma Marshall

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years	Months	Days	If less than one day
About 32			hrs. min.

9. Birthplace: Phila Pa

(Town, county, and state)

10. Usual occupation: Auto

11. Industry or business:

FATHER 12. Name: Charles B Marshall

13. Birthplace: Phila Pa.

MOTHER 14. Maiden name: Matilda Schevaar

15. Birthplace: Phila Pa

16. Informant: Charles B. Marshall

Address: Pine Hill New Jersey

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 1945 (month) (day) (year)

Cemetery or crematory:

Location: Camden N. J.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. Aug. 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 4th 1945, at Hahnemann

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suicide by Hanging	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of 8-4-45

Where did injury occur? Annapolis (City or town) Md (County) (State)

Injured at home, farm, industry, public place (where?) Police Station

Means of injury: Hanging Injured at work?

23. SIGNATURE: Walton H Hamm M D

Address: Annapolis Md Date signed: 8-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-C)

07699

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 845 Lemmon Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME

MURPHY - LENA

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1897 (?)

8. AGE: Years	Months	Days	If less than one day
48 ?	unknown		--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 13, 1945 (month) (day) (year)

Cemetery or crematory: Western Star

Location: Baltimore County

18. Funeral director: Jos. A. Livly

Address: 661 W. Barrie, Balto., Md.

19. August 10 1945 (Date rec'd by registrar) Caldwell Woodruff By B.M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1945, at 5:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945, to August 8 1945

and that I last saw her alive on August 8 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 7/31/45
Due to: ---	
Due to: ---	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 8/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

07700

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 month

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 year, 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: Adelina

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ---------

(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

3.(a) FULL NAME: OFFER - WILLIAM

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): March 13, 1930

8. AGE: Years	Months	Days	If less than one day
15	4	22	-- hrs. --- min.

9. Birthplace: Adelina, Calvert County, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: ----

FATHER 12. Name: Bunting Offer

FATHER 13. Birthplace: Huntingtown, Maryland

MOTHER 14. Maiden name: Ellen Mackell

MOTHER 15. Birthplace: Huntingtown, Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: August 7, 1945 (month) (day) (year)

Cemetery or crematory: Patexent

Location: Calvert County

18. Funeral director: P. E. Sewell

Address: Frederick, Maryland

PRINCE

19. 8-6-45 (Date rec'd by registrar) 19-- E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5, 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1944, to August 5, 1945 and that I last saw him alive on August 5, 1945

Immediate cause of death: Status Epilepticus — DURATION: 6 days

Due to: ---------

Due to: ---------

Other conditions: Imbecile

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --------- Date of: -----

Where did injury occur? --------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Herbert Boutwell M. D. or other

Address: Crownsville, Maryland Date signed: 8/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-B)

CERTIFICATE OF DEATH

07701

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Emergency Hospital Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 minutes

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: County:

City or town: Washington D. C. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ANARGYROS L. PAPPANTONIS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: About 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Greece (Town, county, and state)

10. Usual occupation: Restraunt Keeper

11. Industry or business:

FATHER 12. Name: unknown

13. Birthplace: "

MOTHER 14. Maiden name: unknown

15. Birthplace: "

16. Informant: Mrs. Catherine Thomas

Address: Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 8/11/45 (month) (day) (year)

Cemetery or crematory: Chambers Funeral Home

Location: Washington D.C.

18. Funeral director: J. A. Stanbury & Son

Address: Lakeville Md

19. Aug. 11th 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1945, at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: Did Not Attend 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Poison - Drank Lye	1 Hr
Due to	
Due to	
Other conditions Hemorrhage, Cut left wrist	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 8/8/45

Where did injury occur? Owensville AA Co Md (City or town) (County) (State)

Injured at home, farm, industry, public place, (where?): Friend's House

Means of injury: Drank Lye Injured at work? No

23. SIGNATURE: I. B. Hall Def. M. d. Exam. M. D. or other

Address: Lothian Md Date signed 8/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

07702

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 181 Irving George Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 181 Irving George St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jennie Gladis Pruitt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard J. Pruitt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 24, 1906

8. AGE: Years	Months	Days	If less than one day
39	6	9	hrs. min.

8. Birthplace: Annapolis A A Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: James Causey

13. Birthplace: Washington

MOTHER — 14. Maiden name: Jeannette Clark

15. Birthplace: Annapolis

16. Informant: Howard J. Pruitt

Address: 181 Irving George St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 5, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: Jas. M. Taylor

Address: 149-149 Clay St.

19. Aug 5 45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2, 19 45, at 8 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 19 44 to Aug 2 19 45

and that I last saw her alive on Aug 2 19 45

Immediate cause of death	DURATION
Carcinoma of Cervix with Metastasis to Bone	1 Yr
Due to: Ligament Bladder & Rectum	7 Yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Bond, M. D. or other

Address: Annapolis Md. Date signed: 8-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Penn)

CERTIFICATE OF DEATH

07703

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Accident

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 10 Cornhill Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Victoria Rebecca Randall

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 8/1/1940

8. AGE:

Years	Months	Days	If less than one day
5	0	29	..... hrs. ..... min.

9. Birthplace: Annapolis Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER

12. Name: Walter Randall

13. Birthplace: Annapolis Md

MOTHER

14. Maiden name: Claudia Smith

15. Birthplace: Annapolis, Md.

16. Informant: Walter Randall

Address: 10 Cornhill St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)

Cemetery or crematory: Bureau Hill

Location: West St. Extended

18. Funeral director: Ethel L. Hickspen Sythia Johnson

Address: 43-45 Northwest St.

19. Sept. 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 30 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; ~~My attended deceased from~~ Post-mortem Examination to Aug 30 1945 and ~~that I last saw deceased alive on~~

Immediate cause of death	DURATION
Fracture of neck	sudden
Due to: Accident (hit by	
Due to: auto-trucks)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8-30-45

Where did injury occur? Annapolis (City or town) Anne Arundel (County) Md (State)

Injured at home, farm, industry, public place (where?): Cornhill Street

Means of injury: auto-truck Injured at work? No

23. SIGNATURE: John M. Caffy Deputy Medical Examiner

M. D. or other

Address: Annapolis, Md. Date signed: 8-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07704

Reg. Diat. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

MARYLAND HOUSE OF CORRECTION

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

HARRY RIDER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Elizabeth Rider

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	4	hrs. min.

9. Birthplace: Indiana (Town, county, and state)

10. Usual occupation: Bar tender

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: "

15. Birthplace:

16. Informant: MARYLAND HOUSE OF CORRECTION

Address: Jessups, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/7/45 (month) (day) (year)

Cemetery or crematory: Schwartzie

Location: Balto.

18. Funeral director: Philip Henry Sons

Address: 2024 Pleasant St

19. Aug 6 1945 (Date rec'd by registrar) Clara Baetzle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1945, at 9:45 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 23 1945, to August 4 1945 and that I last saw him alive on August 4 1945

Immediate cause of death: Congestive heart failure with edema of the lungs. — DURATION

Due to: Cardiovascular disease, Chronic asthma, and

Due to: Carcinoma of the tongue with metastasis in the glands of the neck and probably of the lungs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Clark M. D. or other

John A. Clark, M.D.,

Address: Jessups, Maryland Date signed 8/4/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

★ 07705

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Melvina Rosenwinkle

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, Married, Widowed, or Divorced
F	W	Widow

6.(b) Name of husband or wife: Gustav Rosenwinkle Deceased

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) October 22, 1882

8. AGE: Years 62 | Months 8 | Days 22 | If less than one day ____ hrs. ____ min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name William Street.

13. Birthplace Harford Co. Md.

MOTHER 14. Maiden name Josephine Snow.

15. Birthplace Baltimore, Md.

16. Informant Palmer E Rosenwinkle

Address Ferndale 25, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 15 1945 (month) (day) (year)

Cemetery or crematory Louden Park Cem.

Location Baltimore, Md.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. Aug 15 1945 (Date rec'd by registrar) Mildred Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13-45 2:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15-45 19... to Aug 13-45 19..45

and that I last saw h... alive on Aug 13-45 19...

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Carcinoma Stomach	1½
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Glen Burnie Md Date signed Aug 13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07706

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: ~~Annapolis~~ A. A. Co
City or town: ~~West River~~ Md Emergency Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md
County: A. A. Co
City or town: Gales Ville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Beatrice Sellman

3. (b) Social Security Number: 220-22-7211

4. Sex: F.
5. Color or race: Col
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Howard Sellman Jr.
6. (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 12 1909

8. AGE: Years: 35 | Months: | Days: | If less than one day ... hrs. ... min.

9. Birthplace: Bristol
(Town, county, and state)
10. Usual occupation: General House work
11. Industry or business:

FATHER
12. Name: Thomas Sharps
13. Birthplace: Harwood

MOTHER
14. Maiden name: Louise Sharps
15. Birthplace: Harwood

16. Informant: Howard Sellman Jr
Address: West River Md

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Aug. 6. 1945
(month) (day) (year)
Cemetery or crematory: ~~[illegible]~~ Daniel Star Church
Location: West River Md
18. Funeral director: F. A. Hardesty & Son
Address: Galesville Md.

19. Aug 4, 1945
(Date rec'd by registrar)
Wm [illegible] — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Aug 1945, to 3 Aug 1945 and that I last saw her alive on 3 Aug 1945

	DURATION
Immediate cause of death: acute myocardial failure	
Due to: Chronic Myocarditis	
Due to: Coronary occlusion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Emile H. Wilson M.D.
M. D. or other
Address: Lothian, Md.
Date signed: 3 Aug '45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-0)

CERTIFICATE OF DEATH

07707

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sappington Road,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Rose Shai

3.(b) Social Security Number NONE

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Frank Shai Deceased.

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 15, 1884

8. AGE: Years: 61 Months: 2 Days: 5 If less than one day: ____ hrs. ____ min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: House keeping

11. Industry or business: own home

FATHER

12. Name: Ellick Heweig

13. Birthplace: Poland

MOTHER

14. Maiden name: Unknown

15. Birthplace: Poland

16. Informant: Mrs. Frances Milwicz

Address: Odenton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 23, 1945 (month) (day) (year)

Cemetery or crematory: St. Marys of The Field

Location: Millersville, Md.

18. Funeral director: Leo W. Singleton

Address: Glen Burnie, Md.

19. Aug 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 1945, at 7 45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14 1945 to Aug 20 1945 and that I last saw h... alive on Aug 20, 1945

Immediate cause of death	DURATION
Cardio-Renal disease	Unknown
Due to: Hypostatic Pneumonia	4 days
Due to: Edema of Lungs	6 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: John M. Caffy M.D., M. D. or other

Address: Annapolis, Md. Date signed 8-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

07708

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.Co.

City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A.A.Co.

City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. Viewing Ave. & Medora Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife David E. Smith

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 3/28/1870

8. AGE:	Years	Months	Days	If less than one day
	75	4	12	...hrs. ...min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Kraft

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mr. David E. Smith

Address Viewing Ave. & Medora Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13/45 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Frederick Road.

18. Funeral director Wm. J. Tickner & Sons

Address North & Pa. Aves.

19. 8/10 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1945, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 7 1945, to Aug 10 1945

and that I last saw h.. alive on Aug. 10 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to Arteriosclerosis	5 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Ball Jr MD M. D. or other

Address Linthicum Date signed 8-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

07709

★ Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Anne Arundel County Home
How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: County:
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Dora Spencer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Widow

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown.

8. AGE: Years: 62(?) Months: Days: If less than one day: hrs. min.

9. Birthplace: Boston (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Wm. Tucker
Address: Edgewater Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 1. 1945 (month) (day) (year)
Cemetery or crematory: Co Home Cemetery
Location: Edgewater, Md

18. Funeral director: H. L. Handley & Son
Address: Gabsville Md

19. Sept 1 1945 (Date rec'd by registrar) Edward Callenson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1945, at 4 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 2 1945, to Aug 31 1945
and that I last saw h[illegible] alive on Aug 26 1945

Immediate cause of death	DURATION
Chr. Nephritis c Edema	1 mo +
Due to: Chr. Myocarditis	?
Due to: Hypertension c arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. J. Klassen, M.D. M. D. or other
Address: 31 Saltgate Av Date signed: 9/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

07710

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a a

City or town: Germantown Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 Yrs

Hospital, Institution, or street address where death occurred:
16 Brewer ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Germantown Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Brewer Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Noel Davidson Stellings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Camilla Stellings

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Sept 23 — 1901

8. AGE: Years	Months	Days	If less than one day
43	10	19	..... hrs. ..... min.

9. Birthplace: Harwood Md.
(Town, county, and state)

10. Usual occupation: Mail Carrier

11. Industry or business

FATHER
12. Name: Byron N Stellings
13. Birthplace: Harwood Md

MOTHER
14. Maiden name: Elizabeth Norfolk
15. Birthplace: Calvert Co

16. Informant: Camilla Stellings

Address: 16 Brewer ave annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 13/45 (month) (day) (year)

Cemetery or crematory: St mary's

Location: annapolis : md.

18. Funeral director: B L Hopkins

Address: annapolis Md.

19. Aug 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1945, at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 1945, to Aug 10, 1945 and that I last saw him alive on Aug 10, 1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis	3 hours
Due to:	
Due to:	
Other conditions: (None)	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Gilbert R. Anderson M.D.
M. D. or other

Address: Annapolis, Md. Date signed: Aug 13 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07711-21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: St Margarets
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: St Margarets
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Stinchcomb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov 14th 1861

8. AGE:

Years	Months	Days	If less than one day
83	9	9	...hrs. ...min.

9. Birthplace: Anne Arundel Co Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: William Stinchcomb
13. Birthplace: Anne Arundel Co Md.

MOTHER
14. Maiden name: Rosena Pumphrey
15. Birthplace: Anne Arundel Co Md

16. Informant: R. Feldmeier Brice 3rd
Address: Church Circle Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25th 1945 (month) (day) (year)
Cemetery or crematory: Family Plot
Location: New St Margarets A.A.Co Md.

18. Funeral director: John W. Taylor & Son
Address: Annapolis Md.

19. Aug 25 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23, 1945 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1945 to Aug 23 1945
and that I last saw h... alive on Aug 23 1945

Immediate cause of death	DURATION
a Intersusception	
Due to Cardio-Vascular disease	5yrs.
Due to	
Other conditions Senility Arteriosclerosis Chronic Heart (Include pregnancy within 3 months of death)	Months

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gilbert L. Underdonk M. D. or other
Address: Annapolis Md Date signed: 8-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07712

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: County Anne Arundel City or town Churchton. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A.A.

City or town CHURCH TON (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alexander Thompson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	MARRIED.

6.(b) Name of husband or wife Sarah Thompson. 6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Feb. 1868

8. AGE: Years	Months	Days	If less than one day
77	6		hrs. min.

9. Birthplace Churchton, Anne Arundel, Md. (Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business

FATHER 12. Name John Henry Thompson.

FATHER 13. Birthplace Churchton Md.

MOTHER 14. Maiden name Laura Jane Haines

MOTHER 15. Birthplace Balto. Md.

16. Informant Laura Burton

Address Churchton Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 5 1945 (month) (day) (year)

Cemetery or crematory

Location Churchton Md.

18. Funeral director W. E. Jones, Co. Inc.

Address 1432 - U St. N.W. Wash. D.C.

19. Aug 2 1945 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28, 1945, to August 1st 1945 and that I last saw h[illegible] alive on August 1st 1945

	DURATION
Immediate cause of death Chronic hypertrophy	6 mo
Due to Cerebro-Sclerosis	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. E. Robertson M. D. or other

Address Annapolis Md. Date signed 8/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

07713

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 19 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: THOMPSON - ROSS

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): May 1, 1880

8. AGE: Years	Months	Days	If less than one day
65	3	15	... hrs. --- min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER — 12. Name: Ross Thompson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Aug 29 45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt Hospital

Address:

19. Aug 29 1945 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1945, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 27 1945 to August 16 1945 and that I last saw him alive on August 16 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 5/2/45
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert J. Thompson M. D. or other

Address: Crownsville, Maryland Date signed: 8/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07714

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
79 Franklin Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 79 Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Adolph Yororsky

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Yororsky
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 21, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	17	hrs. min.

9. Birthplace: Bohemia (Town, county, and state)
10. Usual occupation: U. S. Navy Band-Ret.
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Anna Yororsky
Address: 79 Franklin Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11 1945 (month) (day) (year)
Cemetery or crematory: U.S. National Cemetery
Location: Annapolis, Md.
18. Funeral director: John M Taylor
Address: Annapolis Md

19. Aug 10 19 45 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 19 45, at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
D 19 to 19
and that I last saw h Deceased 19
Immediate cause of death — DURATION

	DURATION
Acute Cardiac Dilatation	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Walton H Hopkins M D
Deputy Medical Examiner M. D. or other
Address: Annapolis Md Date signed: 8-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (149E)

07715

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Bay Ridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Brunswick ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henriella R Townsend

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
+	w	married

6.(b) Name of husband or wife: Earl M Townsend

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Feb 21 - 1907

8. AGE:

Years	Months	Days	If less than one day
38	5	23	..... hrs. ..... min.

9. Birthplace: Cumberland. md (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER

12. Name: Maurice Robinette

13. Birthplace: Maryland

MOTHER

14. Malden name: Lorena M Ashley

15. Birthplace: Maryland

16. Informant: Earl M Townsend

Address: Bay Ridge. md

17. Removal (Burial, cremation, or removal, Which?) Date thereof: aug 15/45 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland md

18. Funeral director: R. I Happing

Address: annapolis. Md.

19. Aug 15, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 14 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1945, to Aug 14 1945

and that I last saw h... alive on Aug 14 1945

Immediate cause of death	DURATION
Paralytic Ileus	3 days
Generalized Peritonitis	3 days
Due to Caesarean Section	6 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Fibroma at Uterus

Uterine Inertia Date of op. Aug 8

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Boyd M. D. or other

Address: annapolis md Date signed: 8-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07716

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shadyside
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 67 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: A A.
City or town: SHADYSIDE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give ~~LOCATION~~)
2.(a) If veteran, name war

3.(a) FULL NAME: LORENZY TURNER

3.(b) Social Security Number: 220-07-1894

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: Annie TURNER
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): May 1, 1878

8. AGE:

Years	Months	Days	If less than one day
67	3	6	hrs. min.

9. Birthplace: Shadyside AA. Co MD.
(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: oystering & fishing

FATHER
12. Name: John T. TURNER
13. Birthplace: MD.

MOTHER
14. Maiden name: Juliana Mack
15. Birthplace: unknown

16. Informant: Annie TURNER
Address: Shadyside, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 8/10/45 (month) (day) (year)
Cemetery or crematory: St Matthews
Location: Shadyside MD

18. Funeral director: T.A Hardesty & Son
Address: Edgewater, MD.

19. Aug 11 1945 (Date rec'd by registrar) J B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1945 at 5 45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: did not attend 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Pulmonary T.B.	
Due to: Chronic Myocarditis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: J. B. Dent M.D.
Deputy Medical Examiner
Address: Lothian, Md. Date signed 8/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8a

07717

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 yrs

Hospital, Institution, or street address where death occurred:

10 Frances

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Frances

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Agnes M. Walton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 19 – 1867

8. AGE:

Years	Months	Days	If less than one day
77	11	18	..... hrs. ..... min.

9. Birthplace: annapolis. md.

(Town, county, and state)

10. Usual occupation: House Work

11. Industry or business

FATHER

12. Name: Wm Henry Robert Walton

13. Birthplace: St mary's Co

MOTHER

14. Maiden name: Juliana Ballard Kent

15. Birthplace: a a Co md.

16. Informant: Gertrude Farrell Walton

Address: 10 Frances St annapolis. md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9/45 (month) (day) (year)

Cemetery or crematory: St mary's

Location: annapolis. md

18. Funeral director: B L Hopkins

Address: annapolis. md

19. Aug. 8 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1945, at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to August 6 1945

and that I last saw h.. alive on August 6 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 years

3rd attack

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Walton H Hopkins M D

M. D. or other

Address: annapolis, Md Date signed 8-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

★ 07718 21

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A. County

City or town Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. County

City or town Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Waters

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1880

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Stephen Waters

13. Birthplace Baltimore, Md.

14. Maiden name Katherine Russell

15. Birthplace Baltimore, Md.

16. Informant Mrs. Margaret J. Stinchcomb

Address Severna Park, Md.

17. Burial Date thereof Aug. 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadowridge Memorial Park

Location Dorsey, Md.

18. Funeral director John F. Dempsey, Inc.

Address 715 Light St.

19. Aug 20 1945 Mae Alba
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1945 at 10.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/18/45 to 19

and that I last saw h... alive on 8/18/45 19

Immediate cause of death	DURATION
Coronary Thrombosis	Unknown
Due to	
Due to	
Other conditions Chronic Endocarditis, Chronic Interstitial Nephritis, Arteriosclerosis	Many Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Alexander M. D. or other

Address Severna Park Date signed 8/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

07719

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Indian Landing, Millersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2402 Everton Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Floyd N. West

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elizabeth West
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE:

Years	Months	Days	If less than one day
45			..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation: Branch Manager
11. Industry or business: Standard Brands Inc.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory
Location

18. Funeral director
Address

19. 8/17 45 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1945 at 6 00 p.m.

21. I CERTIFY that death occurred on the date above stated; [redacted]
Postmortem Examination
[redacted] on Aug. 17, 1945

Immediate cause of death	DURATION
Accidental drowning	
Due to: ~~Acute Dilatation of Heart~~ cyst	~~acute~~
Due to: ~~hyperten~~ While in swimming in Severn River, near Indian Landing	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of August 17th, 1945
Where did injury occur? Indian Landing (City or town) Anne Arundel (County) Md. (State) 6 P.M.
Injured at home, farm, industry, public place (where?) in the Severn River
Means of injury: Accidental drowning Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
Address: Annapolis, Md. Date signed 8/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07720

Reg. Dist. No. 20

1. PLACE OF DEATH:

County aa

City or town Tracys Landing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County aa

City or town Tracys Landing

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eldridge Wilkerson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Iva Wilkerson

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1877

8. AGE: Years	Months	Days	If less than one day
69	10	19	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Benj. Wilkerson

13. Birthplace Md

MOTHER 14. Maiden name Henrietta Tucker

15. Birthplace Md

16. Informant Benj. Wilkerson

Address Tracys Landing

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept 2nd 1945 (month) (day) (year)

Cemetery or crematory Friendship. Cem

Location Friendship. Md

18. Funeral director Harry Hutchins

Address Deale Md

19. Sep 1st 1945 H. H. Clayton

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 31 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jul 1945 to Aug 31 1945

and that I last saw h[illegible] alive on Aug 31 1945

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hugh W Ward M. D. or other

Address Deale Md Date signed 8/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 07721

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 Heaver Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: WILSON - REBECCA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widow

6.(b) Name of husband or wife: --------
6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 50 | Months: unknown | Days: | If less than one day: ---- hrs. ----- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: --------

FATHER
12. Name: Jack Miller
13. Birthplace: Virginia

MOTHER
14. Maiden name: Viner ?
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 7, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Anne Arundel County

18. Funeral director: Rayner Sanders
Address: 1412 E. Preston St., Balto., Md.

19. 8 6 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 19 45 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 19 45 to August 3 19 45 and that I last saw her alive on August 3 19 45

Immediate cause of death: Chronic Myocarditis and Chronic Bronchitis — DURATION: Known to us since 7/18/45

Due to: --------

Due to: --------

Other conditions: Toxic Delirium — Known to us Since admission

(Include pregnancy within 3 months of death)

Major findings of operations: --------
Date of op.: ------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: ------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? --------

23. SIGNATURE: Herbert J. Wright M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 8/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15